CHRISTOPHER WAYNE LESTER
MADISON MEDICAL GROUP
RECORDS
14-I

MADISON MEDICAL, PLLC
705 MADISON AVENUE
MADISON, WV 25130
PHONE (304) 369-5170
FAX (304) 369-1742

Date: 12/4/02

WV WORKER'S COMPENSATION
P.O. BOX 431
CHARLESTON,WV 25322-0431

TO WHOM IT MAY CONCERN:

Please authorize the purchase of the following medications for this patient for the treatment of his/her compensable injury.

Sincerely,

Physician: Dr. John M. Snyder DO

Patient: Christopher Lester

SSN: [redacted]3340

Claim No.: 2000046841 DOI: 3/10/00

RX'S: Oxycontin 40mg 1 PO BID X5 refills

For the treatment of : 847.0

Telephone: (304) 369-5170 DEA #AS 3212329

JOHN M. SNYDER, D.O.

705 Madison Avenue Madison, WV 25130

Name Christine Lester Date 12-2-

Address

℞ Seroquel 400
#60
1 po HS

D.O.

This prescription may be filled with a generically equivalent drug product unless the words "Brand Necessary" or "Brand Medically Necessary" are written, in the practitioner's own handwriting, on this prescription form.

☐ Label

Refill 0 - 1 - 2 - 3 - 4 - PRN

Debbie please Authorize through Comp

* * * Transmission Result Report (MemoryTX) (Oct.24. 2002 1:39PM) * * *

File No.	Mode	Destination	Pg(s)	Result	Page Not Sent
2981	Memory TX	13049266092	P. 2	OK	

Reason for error
E.1) Hang up or line fail
E.2) Busy
E.3) No answer
E.4) No facsimile connection

MADISON MEDICAL, P.L.L.C.
705 MADISON AVENUE
MADISON, WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

FAX COVER SHEET

TO: Workers Comp

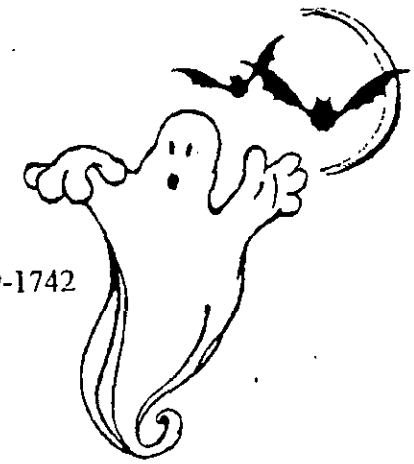
FROM: Debbie

RE: Christopher Lester

NUMBER OF PAGES INCLUDING COVER SHEET: 2

DATE: 10/24/02

ADDITIONAL COMMENTS: Rx attch



MADISON MEDICAL, P.L.L.C.
705 MADISON AVENUE
MADISON, WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

FAX COVER SHEET

TO: Workers Comp

FROM: Debbie

RE: Christopher Lester

NUMBER OF PAGES INCLUDING COVER SHEET: 2

DATE: 10/24/02

ADDITIONAL COMMENTS: Rx auth

FAXED By: DK Date: 10/24/02

500688.015.0264

MADISON MEDICAL, PLLC
705 MADISON AVENUE
MADISON, WV 25130
PHONE (304) 369-5170
FAX (304) 369-1742

Date: 10/24/02

WV WORKER'S COMPENSATION
P.O. BOX 431
CHARLESTON,WV 25322-0431

TO WHOM IT MAY CONCERN:

Please authorize the purchase of the following medications for this patient for the treatment of his/her compensable injury.

Sincerely,

Physician: Dr. John Snyder

Patient: Christopher Lester

SSN: [redacted] - 3340

Claim No.: 2000046841 DOI: 3-10-00

RX'S: Oxycontin 40mg 1 T10 X 3 refills

For the treatment of : 847.0, 847.1, 847.2, 959.01
296.23

FAXED By: KM Date: 10/24/02

500688.015.0265

MADISON MEDICAL, PLLC
705 MADISON AVENUE
MADISON, WV 25130
(304) 369-5170 FAX (304) 369-1742

[redacted]/Jr PATIENT NAME Chris Lester ACCT # 49564

DX: Chronic LBP

AUTHORIZATION # Work Comp

REFERRING DOCTOR 3

PHONE # 369-6657 CONTACT NAME _____

REQUEST FOR: Flu - Pain Clinic

SCHEDULED WITH Dr Saldanha 925-2222

DATE/TIME April 29, 2002 925-3535
12:00 noon

RECORDS:
_____SENT BY MAIL
_____FAXED
_____GIVEN TO PT TO HAND DELIVER

4-18-02 PT WAS NOTIFIED OF DATE, TIME AND ANY SPECIAL INSTRUCTIONS.

* Pt says he has only missed Nov. appt - says he has tried to call & they have not given him appt /JB

Pain Management says
* Pt missed appts on
(Nov. 2001
March 28, 2002
His call intercept & they cannot get thru /JB

500688.015.0266

MADISON MEDICAL, P.L.L.C.
705 MADISON AVE.
MADISON, WV 25130
PHONE# (304)369-5170 FAX# (304)369-1742

MEDICAL RECORDS RELEASE AUTHORIZATION

TO: J. M. Snyder DO
DOCTOR

ADDRESS: _____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:
Patient

THE COMPLETE RECORDS IN YOUR POSSESSION CONCERNING MY ILLNESSES AND/OR TREATMENTS DURING THE PERIOD FROM:

Nov. 2000 TO June 2001

NAME: Christopher Lester DATE: 06-06-01

ADDRESS: P.O. Box 1113
Danville WV 25053

BIRTHDATE: [redacted]-71 SSN# [redacted] 5240

SIGNATURE: Christopher M. Lester
(IF RELATIVE STATE RELATION)

WITNESS: Freda Botts

THIS RELEASE AND AUTHORIZATION SHALL BE VALID FOR ONE YEAR FROM ITS DATE OF SIGNATURE UNLESS TERMINATED IN WRITING BEFORE THAT DATE.

*If a fee is required for records please pre-bill. The physicians office will not be responsible for any fees incurred.

usual charge

Will Copies done/PB

MADISON MEDICAL, PLLC
705 MADISON AVENUE
MADISON, WV 25130
(304) 369-5170 FAX (304) 369-1742

[redacted]/74 PATIENT NAME Chris Lester ACCT # 49564

DX: Chronic LBP & shoulder pain

AUTHORIZATION # Work Comp # 300013144

REFERRING DOCTOR 3

PHONE # 369-6657 CONTACT NAME 369-9246 April ck

REQUEST FOR: ortho consult

SCHEDULED WITH Dr Surface 766-7515

DATE/TIME May 14 2:30pm

RECORDS Request
_____ SENT BY MAIL
4-26-01 ~~FAXED~~ Mailed
_____ GIVEN TO PT TO HAND DELIVER

take films

5-7-01 PT WAS NOTIFIED OF DATE, TIME AND ANY SPECIAL INSTRUCTIONS.

GP/GP [redacted] RC

AUTHORIZATION FOR MEDICAL R[illegible]ORDS MEDDIC #

AUTHORIZATION VOID AFTER 60 DAYS APQ

WVDDS-17
01 AUG 99

State of WV, Disability Determination Section	Claimant's Soc. Sec. No.	Claimant's Telephone No.
500 QUARRIER STREET, SUITE 500 CHARLESTON, WV 25301	[redacted]3340	
Location Code: Charleston 5010 X — Clarksburg 5020	Claimant's Name & Address LESTER CHRISTOPHEW P O BOX 1113 DANVILLE WV 25053	

VENDOR'S NAME & ADDRESS (Include ZIP)

MADISON MEDICAL GROUP
MEDICAL RECORDS
705 MADISON AVE.
MADISON WV 25130

95 33/3004

550 628 506
Vendor's FEIN

For prompt payment, please correct name & address if typed incorrectly.

DIB	SSI	SSI/DIB	SA Code
002 X	016	216	10-025

Authorization No.	Obligation Date	Examiner Code
01218222	01/17/01	192

TO THE VENDOR: You, the vendor, are hereby authorized to furnish medical records regarding the above-named person. We the Disability Determination Section, will pay your usual and customary cost/fee for such record(s) not to exceed the maximum contained in our fee schedule. By accepting this authorization, you hereby agree not to make any charge to either the claimant or his family for any goods/services authorized herein.

Examiner's Signature and Date
GREG PHILLIPS 01/17/01

EXPLANATION

We are processing the above-named person's claim for disability-related benefits under the Social Security Act. All available medical information is needed which is pertinent to that claim. The claimant's authorization for release of medical records and a return envelope are enclosed.

CODE	DETAILS	COST/FEE	DDS Use Only
☑ 99081	Duplicating Medical Records and/or Completion of Agency Reporting Form.	11	
☐ 99080	Comprehensive Abstract: Summary by Physician, Including Dates, History and Findings and Duplicated Records.		
☐	Other (specify)		
☐ No Charge			
FAX # 304-353-4219	TOTAL	11 00	

Date of Alleged Disability	Date(s) of Treatment	
		DOB: [redacted]1971

Comments Section

PLEASE SEE ATTACHED
PLEASE SEND COPIES OF EVERYTHING SINCE 9/26/00. WE JUST NEED OUR RECORDS UPDATED.

AB 1-24-01
10-11-00 to 1-12-01
UNOTE
EEG

INSTRUCTIONS TO VENDOR: This document also may serve as your invoice. If you desire to submit your invoice using this document, (1) check the appropriate box under the description section above, (2) enter your cost/fee, (3) complete the vendor certification below, (4) return the original and next copy with the record(s), and (5) retain the last copy for your files. (6) In order to process this authorization for payment, we need a clearly written ORIGINAL signature. We cannot accept an INITIALED, TYPED OR STAMPED signature.

VENDOR CERTIFICATION: I, the vendor, hereby certify that this is the original invoice, that the goods/services authorized herein have been furnished, and that payment has not been received.	Vendor Authorized Signature and Date
AGENCY CERTIFICATION: I, an authorized agent of the Disability Determination Section, hereby certify that the goods/services authorized herein have been received and are approved for payment.	Agency Authorized Signature and Date

1. ORIGINAL INVOICE COPY | 2. INVOICE COPY | 3. VENDOR'S FILE COPY

	TO BE COMPLETED BY SSA
	NUMBER HOLDER Christopher Wayne Lester
	SOCIAL SECURITY NUMBER [redacted] 3340
	EMPLOYEE/CLAIMANT/BENEFICIARY *(If other than Number Holder)*

AUTHORIZATION FOR SOURCE TO RELEASE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

INFORMATION ABOUT MEDICAL OR OTHER SOURCE-PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS OF SOURCE *(Include Zip Code)*	RELATIONSHIP TO DISABLED PERSON
Madison Med. Group	

INFORMATION ABOUT DISABLED PERSON-PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS *(If known)* AT TIME DISABLED PERSON HAD CONTACT WITH SOURCE *(Include Zip Code)*	DATE OF BIRTH	DISABLED PERSON'S I.D. NUMBER *(If known and different than SSN) (Clinic/Patient No.)*

APPROXIMATE DATES OF DISABLED PERSON'S CONTACT WITH SOURCE *(e.g., dates of hospital admission, treatment, discharge, etc.)*

TO BE COMPLETED BY DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF

GENERAL AND SPECIAL AUTHORIZATION TO RELEASE MEDICAL AND OTHER INFORMATION IN ACCORDANCE WITH THE PROVISIONS OF THE SOCIAL SECURITY ACT; THE PUBLIC HEALTH SERVICE ACT, SECTIONS 523 AND 527; AND TITLE 38 U.S.C. VETERANS BENEFITS, SECTION 4132.

I hereby authorize the above-named source to release or disclose to the Social Security Administration or State agency the following information for the period(s) identified above:

1) All medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV), or sexually transmitted diseases;
2) Information about how my impairment(s) affects my ability to complete tasks and activities of daily living;
3) Information about how my impairment(s) affected my ability to work.

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above.

I understand that this authorization, except for action already taken, may be voided by me at anytime. If I do not void this *authorization, it will automatically* end when a final decision is made on my claim. If I am already receiving benefits, the authorization will end when a final decision is made as to whether I can continue to receive benefits.

READ IMPORTANT INFORMATION ON REVERSE BEFORE SIGNING FORM BELOW.

SIGNATURE OF DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF	RELATIONSHIP TO DISABLED PERSON (If other than self)	DATE
Christopher Wayne Lester Sr.		1/12/01

STREET ADDRESS	TELEPHONE NUMBER (Area Code)
P. O. Box 1113	304-369-6657

CITY	STATE	ZIP CODE
Danville	WV	25053

The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by the Social Security Administration, but without it the source may not honor this authorization.

SIGNATURE OF WITNESS	STREET ADDRESS	
CITY	STATE	ZIP CODE

Form SSA-827 (1-97) Use Prior Editions

(OVER)

500688.015.0270

MADISON MEDICAL, P.L.L.C.
705 MADISON AVENUE
MADISON, WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

FAX COVER SHEET

TO: Mari Sullivan Walker

FROM: Freda L. DeSnyder

RE: Christopher Lester

NUMBER OF PAGES INCLUDING COVER SHEET: 24

DATE: 01-16-01

ADDITIONAL COMMENTS:

THANK YOU.

FAXED 01/16/01 3p

Psychologist Marj Sullivan Walker Pineville 732-9132 732-6589 FAX
alt Gloria Box 123 Pineville WV Work Comp c dx code
Jan 17, 2001 11:30am 4hrs

[redacted]

PATIENT N/ [redacted] # 49564

DX: ongoing anxiety & depression

INSURANCE: Work Comp

AUTHORIZATION#:

REFERRING DOCTOR: JMS

PHONE#: 369-6657 CONTACT NAME:

REQUEST FOR: psychiatry consult

SCHEDULED WITH: Marj Sullivan Walker (Psychologist) 12/15/00 ~~341-1800~~

DATE/TIME: Jan 17, 2001 732-9132 ~~Jermone KMC~~ (WVU/Behavioral Med)
11:30am
(4 hrs visit)
Bx 123
Pineville

alt Gloria
RECORDS: Comp Auth c codes
_____ SENT BY MAIL
01-16-01 FAXED 732-6589
_____ GIVEN TO PT TO HAND DELIVER

✓ PT WAS NOTIFIED OF DATE, TIME AND ANY SPECIAL INSTRUCTIONS.

AUTHORIZATION FOR MEDICAL RE RDS
DP/DP IN MEDDIC #

AUTHORIZATION VOID AFTER 60 DAYS

WVDDS-17
01 AUG 99

State of WV, Disability Determination Section

500 QUARRIER STREET, SUITE 500
CHARLESTON, WV 25301

Location Code: Charleston 5010 X Clarksburg 5020

Claimant's Soc. Sec. No.	Claimant's Telephone No.
[redacted]3340	

Claimant's Name & Address

LESTER CHRISTOPHEW

P O BOX 1113
DANVILLE WV 25053

VENDOR'S NAME & ADDRESS (Include ZIP)

MADISON MEDICAL GROUP
ATTN: MEDICAL RECORDS
705 MADISON AVE.
MADISON WV 25130

Smart Corp

55-3313004
550 628 506
Vendor's FEIN

For prompt payment, please correct name & address if typed incorrectly.

DIB	SSI	SSI/DIB	SA Code
002 X	016	216	10-025

Authorization No.	Obligation Date	
00171027	09/22/00	200 Examiner Code

TO THE VENDOR: You, the vendor, are hereby authorized to furnish medical records regarding the above-named person. We the Disability Determination Section, will pay your usual and customary cost/fee for such record(s) not to exceed the maximum contained in our fee schedule. By accepting this authorization, you hereby agree not to make any charge to either the claimant or his family for any goods/services authorized herein.

Examiner's Signature and Date Debbie Pauley 09/22/00
DEBBIE PAULEY 09/22/00

EXPLANATION

We are processing the above-named person's claim for disability-related benefits under the Social Security Act. All available medical information is needed which is pertinent to that claim. The claimant's authorization for release of medical records and a return envelope are enclosed.

CODE	DETAILS	COST/FEE	DDS Use Only
☑ 99081	Duplicating Medical Records and/or Completion of Agency Reporting Form.	11 [illegible]	
☐ 99080	Comprehensive Abstract: Summary by Physician, Including Dates, History and Findings and Duplicated Records.		
☐	Other (specify)		
☐ No Charge			
	TOTAL	11 04	

FAX # 304-353-4219

Date of Alleged Disability	Date(s) of Treatment	
03/10/00		DOB: [redacted]1971

Comments Section

PLEASE SEE ATTACHED
ALL MEDICAL RECORDS FROM 1999 TO PRESENT

AB 10-11-00 9-29-00
04-7-00 to
00 Note

INSTRUCTIONS TO VENDOR: This document also may serve as your invoice. If you desire to submit your invoice using this document, (1) check the appropriate box under the description section above, (2) enter your cost/fee, (3) complete the vendor certification below, (4) return the original and next copy with the record(s), and (5) retain the last copy for your files. (6) In order to process this authorization for payment, we need a clearly written ORIGINAL signature. We cannot accept an INITIALED, TYPED OR STAMPED signature.

VENDOR CERTIFICATION: I, the vendor, hereby certify that this is the original invoice, that the goods/services authorized herein have been furnished, and that payment has not been received.	Vendor Authorized Signature and Date
AGENCY CERTIFICATION: I, an authorized agent of the Disability Determination Section, hereby certify that the goods/services authorized herein have been received and are approved for payment.	Agency Authorized Signature and Date

1. ORIGINAL INVOICE COPY | 2. INVOICE COPY | 3. VENDOR'S FILE COPY

500688.015.0273

TO BE COMPLETED BY SSA
NUMBER HOLDER **Christopher W. Lester**
SOCIAL SECURITY NUMBER [redacted]3340
EMPLOYEE/CLAIMANT/BENEFICIARY *(if other than Number Holder)*

AUTHORIZATION FOR SOURCE TO RELEASE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

INFORMATION ABOUT MEDICAL OR OTHER SOURCE-PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS OF SOURCE *(Include Zip Code)*	RELATIONSHIP TO DISABLED PERSON
Madison Med Grp.	

INFORMATION ABOUT DISABLED PERSON-PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS (If Known) AT TIME DISABLED PERSON HAD CONTACT WITH SOURCE *(Include Zip Code)*	DATE OF BIRTH	DISABLED PERSON'S ID NUMBER *(If Known and different than SSN) (Clinic/Patient No.)*

APPROXIMATE DATES OF DISABLED PERSON'S CONTACT WITH SOURCE *(e.g., dates of hospital admission, treatment, discharge, etc.)*

TO BE COMPLETED DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF

GENERAL AND SPECIAL AUTHORIZATION TO RELEASE MEDICAL AND OTHER INFORMATION IN ACCORDANCE WITH THE PROVISIONS OF THE SOCIAL SECURITY ACT; THE PUBLIC HEALTH SERVICE ACT, SECTIONS 523 AND 527; AND TITLE 38 U.S.C. VETERANS BENEFITS, SECTION 4132.

I hereby authorize the above-name source to release or disclose to the Social Security Administration or State agency the following information for the period(s) identified above:

1) All medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV) or sexually transmitted diseases;
2) Information about how my impairment(s) affects my ability to complete tasks and activities of daily living;
3) Information about how my impairment(s) affected my ability to work.

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above.

I understand that this authorization, except for action already taken, may be voided by me at anytime. If I do not void this authorization, it will automatically end when a final decision is made on claim. If I am already receiving benefits, the authorization will end when a final decision is made as to whether I can continue to receive benefits.

READ IMPORTANT INFORMATION ON REVERSE BEFORE SIGNING FORM BELOW.

SIGNATURE OF DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF	RELATIONSHIP TO DISABLED PERSON (If other than self)	DATE
Christopher W. Lester		9/22/00

STREET ADDRESS	TELEPHONE NUMBER (AREA CODE)
P O Box 1113	**304-369-6657**

CITY	STATE	ZIP CODE
Danville	**WV**	**25053**

The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by the Social Security Administration, but without it the source may not honor this authorization.

SIGNATURE OF WITNESS	STREET ADDRESS
[signature]	170 Court Street

CITY	STATE	ZIP CODE
Madison	WV	25130

Form SSA-827 (1-97) Use Prior Editions EF-FF (1-97)

(OVER)

auwh/01-01-96/*6 ** VENDOR COPY ** 1024458

Bob Wise
Governor

Robert J. Smith
Commissioner

West Virginia Bureau of Employment Programs
• Job Service/Job Training Programs • Labor Market Information
• Unemployment Compensation • Workers' Compensation
an equal opportunity/affirmative action employer

April 2, 2001

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Re: Claim 2000046841
S.S.N. [redacted]-3340
D.O.I. 03/10/2000

PLEASE READ CAREFULLY - AUTHORIZATION WITHHELD

The request from Madison Medical, PLLC, dated 03/14/2001, for Ativan 1mg & Paxil 20mg is withheld pending a detailed medical report showing the medical necessity in relation to the compensable injury.

must show relationship before this medication can be considered

If you have any questions or concerns, you may reach me at 304-926-5097.

Workers' Compensation Division
BY: Nena Peay
Claims Representative 3/Senior

CC: D & M TRUCKING CORPORATION INC
KOZAK JOHN H
VASS VOCATIONAL SERVICES

RECEIVED APR [redacted]

audx/1-4-01/*8 ** VENDOR COPY ** 1024458

Bob Wise
Governor
Robert J. Smith
Commissioner

West Virginia Bureau of Employment Programs
• Job Service/Job Training Programs • Labor Market Information
• Unemployment Compensation • Workers' Compensation
an equal opportunity/affirmative action employer

May 14, 2001

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Re: Claim 2000046841
S.S.N. [redacted]-3340
D.O.I. 03/10/2000

PLEASE READ CAREFULLY - NOTICE OF SECONDARY CONDITIONS

The following is a list of both primary and secondary conditions in your claim. Medical expenses related to these conditions will be paid by the Division.

296.23	Major Depressive Disorde
959.01	Other And Injury To Head
847.2	Lumbar Sprain
847.1	Thoracic Sprain
847.0	Neck Sprain

This decision was based primarily on the following: report of Dr. Riaz Riaz dated April 9, 2001.

Any party to this claim may protest this decision within 30 days from the date you receive this letter. You must send a written protest, along with a copy of this order, to the Office of Judges, P.O. Box 2233, Charleston, WV 25328-2233 and to the Supervisor, Claims Defense Litigation, P.O. Box 4317, Charleston, WV 25364-4317. Copies must also be sent to all other parties to the claim.

After the protest is filed, all parties may negotiate a final settlement of any and all issues in a claim, excluding medical benefits. To inquire about settling this claim, contact Workers' Compensation Internal Management Services, Settlement Unit, at P. O. Box 3587, Charleston, WV 25336-3587.

If you have any questions or concerns, you may reach me at 304-926-5097.

Workers' Compensation Division
BY: Nena Peay
Claims Representative 3/Senior

CC: D & M TRUCKING CORPORATION INC
KOZAK JOHN H
RIAZ RIAZ UDDIN MD
VASS VOCATIONAL SERVICES

RECEIVED MAY 15 2001

auth/1-4-01/*8 ** VENDOR COPY ** 1024458

Bob Wise
Governor
Robert J. Smith
Commissioner

West Virginia Bureau of Employment Programs
• Job Service/Job Training Programs • Labor Market Information
• Unemployment Compensation • Workers' Compensation
an equal opportunity/affirmative action employer

May 14, 2001

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Re: Claim 2000046841
S.S.N. [redacted]-3340
D.O.I. 03/10/2000

PLEASE READ CAREFULLY - AUTHORIZATION DECISION

The request from RIAZ RIAZ UDDIN MD dated 04/09/2001, is Approved.

authorization for psychiatric treatment, psychotherapay, and the medication Pamelor 25mg

Authorized Dates are 04/09/2001 through 10/09/2001.

Your authorization number is 300025217.

For procedures, such as surgery, that are authorized and require multiple providers, the attending physician should share the authorization number with those providers to assure payment of their bills.

If it is later determined you are not entitled to authorized services, payment will be recovered.

Any party to this claim may protest this decision within 30 days from the date you receive this letter. You must send a written protest, along with a copy of this order, to the Office of Judges, P.O. Box 2233, Charleston, WV 25328-2233 and to the Supervisor, Claims Defense Litigation, P.O. Box 4317, Charleston, WV 25364-4317. Copies must also be sent to all other parties to the claim.

After the protest is filed, all parties may negotiate a final settlement of any and all issues in a claim, excluding medical benefits. To inquire about settling this claim, contact Workers' Compensation Internal Management Services, Settlement Unit, at P. O. Box 3587, Charleston, WV 25336-3587.

If you have any questions or concerns, you may reach me at 304-926-5097.

Workers' Compensation Division
BY: Nena Peay
Claims Representative 3/Senior

CC: D & M TRUCKING CORPORATION INC
RIAZ RIAZ UDDIN MD
KOZAK JOHN H
RIAZ RIAZ UDDIN MD
VASS VOCATIONAL SERVICES

RECEIVED MAY 15 2001

PH

cnrq/3-27-98/*6 ** VENDOR COPY ** 1024458

Bob Wise
Governor

Robert J. Smith
Commissioner

West Virginia Bureau of Employment Programs
• Job Service/Job Training Programs • Labor Market Information
• Unemployment Compensation • Workers' Compensation
an equal opportunity/affirmative action employer

May 14, 2001

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Re: Claim 2000046841
S.S.N. [redacted]-3340
D.O.I. 03/10/2000

PLEASE READ CAREFULLY - REQUEST FOR INFORMATION

Bluefield Mental Health Center, please send me the following information regarding this claim:

All medical records related to the above claim.

Please provide this office with the psychological component of the psychiatric evaluation.

If you have any questions or concerns, you may reach me at 304-926-5097.

Workers' Compensation Division
BY: Nena Peay
Claims Representative 3/Senior

CC: D & M TRUCKING CORPORATION INC
KOZAK JOHN H
RIAZ RIAZ UDDIN MD
VASS VOCATIONAL SERVICES

RECEIVED MAY 15 2001

auth/09-24-98/*8 ** VENDOR COPY ** 1024458

Bob Wise
Governor
Robert J. Smith
Commissioner

West Virginia Bureau of Employment Programs
• Job Service/Job Training Programs • Labor Market Information
• Unemployment Compensation • Workers' Compensation
an equal opportunity/affirmative action employer

March 28, 2001

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Re: Claim 2000046841
S.S.N. [redacted]3340
D.O.I. 03/10/2000

PLEASE READ CAREFULLY - AUTHORIZATION DECISION

The request from CHARLESTON PAIN MANA dated 02/28/2001, is Approved.

authorization for two (2) sessions facet joint injections to the back and trigger point injections to the cervical

Authorized Dates are 03/27/2001 through 06/27/2001.

Your authorization number is 300010775.

For procedures, such as surgery, that are authorized and require multiple providers, the attending physician should share the authorization number with those providers to assure payment of their bills.

If it is later determined you are not entitled to authorized services, payment will be recovered.

Any party to this claim may protest this decision within 30 days from the date you receive this letter. You must send a written protest, along with a copy of this order, to the Office of Judges, P.O. Box 2233, Charleston, WV 25328-2233 and to the Supervisor, Claims Defense Litigation, P.O. Box 4317, Charleston, WV 25364-4317. Copies must also be sent to all other parties to the claim.

After the protest is filed, all parties may agree to seek mediation services. If so, you may contact the Mediation Unit at P.O. Box 2964, Charleston, WV 25330-2964.

If you have any questions or concerns, you may reach me at 304-926-5097.
Workers' Compensation Division
BY: Nena Peay
Claims Representative 3/Senior

CC: D & M TRUCKING CORPORATION INC

KOZAK JOHN H
VASS VOCATIONAL SERVICES

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Bob Wise
Governor
Robert J. Smith
Commissioner

West Virginia Bureau of Employment Programs
• Job Service/Job Training Programs • Labor Market Information
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an equal opportunity/affirmative action employer

April 3, 2001

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Re: Claim 2000046841
S.S.N. [redacted]3340
D.O.I. 03/10/2000

PLEASE READ CAREFULLY - AUTHORIZATION DECISION

The request from MADISON MEDICAL PLLC dated 03/28/2001, is Approved.

authorization for consultation with orthopedic surgeon

Authorized Dates are 04/02/2001 through 07/02/2001.

Your authorization number is 300013144.

For procedures, such as surgery, that are authorized and require multiple providers, the attending physician should share the authorization number with those providers to assure payment of their bills.

If it is later determined you are not entitled to authorized services, payment will be recovered.

Any party to this claim may protest this decision within 30 days from the date you receive this letter. You must send a written protest, along with a copy of this order, to the Office of Judges, P.O. Box 2233, Charleston, WV 25328-2233 and to the Supervisor, Claims Defense Litigation, P.O. Box 4317, Charleston, WV 25364-4317. Copies must also be sent to all other parties to the claim.

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If you have any questions or concerns, yWorkers' Compensation Division7.
BY: Nena Peay
Claims Representative 3/Senior

CC: D & M TRUCKING CORPORATION INC
KOZAK JOHN H
VASS VOCATIONAL SERVICES

Dr Surface need chart

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April 2, 2001

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Re: Claim 2000046841
S.S.N. [redacted]-3340
D.O.I. 03/10/2000

PLEASE READ CAREFULLY - REQUEST FOR INFORMATION

John Snyder, DO/Madison Medical, PLLC, please send me the following information regarding this claim:

A detailed narrative report.

medical records/dictation

Please supply this office with a weaning and tapering plan for the medication Oxycontin 40mg and also detailed report as to how the need for the medication Paxil and Ativan are directly related to the compensable injury.

If you have any questions or concerns, you may reach me at 304-926-5097.

Workers' Compensation Division
BY: Nena Peay
Claims Representative 3/Senior

CC: D & M TRUCKING CORPORATION INC
KOZAK JOHN H
VASS VOCATIONAL SERVICES

Copied & mailed 4-26-01 JS

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Bob Wise
Governor

Robert J. Smith
Commissioner

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April 3, 2001

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Re: Claim 2000046841
S.S.N. [redacted]-3340
D.O.I. 03/10/2000

PLEASE READ CAREFULLY - NOTICE OF BENEFITS

I have received medical evidence which indicates you continue to be disabled from working from 07/01/2000 through 06/04/2001.

If it is later determined you are not entitled to benefits or expenses, the Division may recover these overpayments.

If medical evidence showing continued disability is not received, your claim may close for temporary total disability benefits on 07/19/2001.

If you have any questions or concerns, you may reach me at 304-926-5097.

Workers' Compensation Division
By: Nena Peay
Claims Representative 3/Senior

CC: D & M TRUCKING CORPORATION INC
KOZAK JOHN H
VASS VOCATIONAL SERVICES

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Workers' Compensation Division - Office of Claims Management
Post Office Box 431, Charleston, West Virginia 25322-0431 • http://www.state.wv.us/bep

500688.015.0282

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Bob Wise
Governor

Robert J. Smith
Commissioner

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• Unemployment Compensation • Workers' Compensation
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April 4, 2001

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Re: Claim 2000046841
S.S.N. [redacted]-3340
D.O.I. 03/10/2000

PLEASE READ CAREFULLY - APPOINTMENT SCHEDULED

You have been scheduled for an appointment on 6/25/01, at 10:30 AM with:

MIR SAGHIR MD Phone: 304-442-5176
P O BOX 839
MONTGOMERY, WV 25136

The above named physician should provide the Division with a narrative report which outlines your medical history, diagnostic studies, physical examination, diagnosis, and prognosis. The following questions should be answered:

1. Has the claimant reached maximum medical improvement? (No additional surgical or medical intervention will change the claimant's condition.)
2. Is the claimant working? If so, in what capacity? If not, could the claimant return to a modified work assignment and with what restrictions?
3. What impairment rating is recommended, using the AMA Guide to the Evaluation of Permanent Impairment, Fourth Edition?

If the claimant has not reached maximum medical improvement, what additional diagnostic studies and/or treatment do you recommend and what benefit should be expected? (Review the WCD Treatment Guides for the diagnosis before making your recommendations.)

This exam was scheduled by the Division and all bills and related expenses should sent to us.

*DR. MIR, PLEASE REFER TO YOUR REPORT OF 12/22/00. NOTE A 10% AWARD WAS GRANTED F THE BACK IN 95-6803. *CLAIMANT, PLEASE BRING ANY NEW X-RAYS. *EXAM REQUESTED BY CLAIMS MANAGER, NENA PEAY.

Failure to keep this appointment may result in the closing of your claim for benefits.

If you have any questions or concerns, you may reach me at 800-628-4265.

Workers' Compensation Division
BY: Deborah Thorne
Independent Med Ex

CC: D & M TRUCKING CORPORATION INC
MIR SAGHIR MD
KOZAK JOHN H
VASS VOCATIONAL SERVICES

RECEIVED APR 0 5 2001

Attending Physician's Report

Return Completed Form To:
Workers' Compensation Division
P.O. Box 3151, Charleston, West Virginia 25332

R DIVISION USE ONLY
Claims Manager Nena Peay
Trucking/Agr & Food Proc
Claimant's County BOONE

WC-219 Rev. 9-94

SECTION I: To be completed by the injured worker (FORM MAY BE RETURNED IF ALL QUESTIONS ARE NOT ANSWERED.)

1. Claim No. 2000046841 SS No. [redacted]-3340
Emp. Fisk No. 98001651 DOI 03/10/2000
2. Current Telephone No. 304-369-5657

Claimant's Name and Address

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Employer's Name and Address

D & M TRUCKING CORPORATION
502 BOB VINES RD
GHENT, WV 25843

Please mark any needed changes in your address as printed above.

Have you performed any kind of work or have you received income for any work during the time you have been certified temporarily and totally disabled? ☐ Yes ☑ No

I hereby certify that the statements and answers set forth above are true and correct to the best of my knowledge and belief. I am aware that the law provides for severe penalties if I knowingly and with fraudulent intent withhold a material fact or make a false statement in order to obtain or increase a benefit that I am not entitled to.
Claimant's Signature Christopher W. Lester Sr Date 3-30-01

SECTION II: To be completed by the Attending Physician (PLEASE COMPLETE ALL QUESTIONS.) Attach Additional Pages If Necessary.

If claimant has reached maximum degree of medical improvement, please complete form WC-219a, NOTICE OF MAXIMUM MEDICAL IMPROVEMENT.

1. Date of this examination 3/22/01 (Month Day Year)
2. Date of next appointment 4/24/01 (Month Day Year)

3. A. Is this the first examination and/or treatment by you for this injury? ☐ Yes ☑ No If Yes, please advise as to how the claimant came under your care.

B. Does claimant continue under your active care? ☑ Yes ☐ No If No, please explain.

C. Has the claimant been referred to another physician for any of the following? (Check appropriate box(es) and explain basis for your referral.)
☑ Consultation ☑ Evaluation ☑ Treatment Pain Management

4. Diagnosis (ICD9-CM) code and description
847.0 847.2
847.1 959.01

5. Please describe your treatment plan and list medications currently being prescribed, their dosages, and the refill limit.
continue meds
F/u with Pain Clinic
request consult ē orthopedic surgeon

6. Has normal or expected recovery been delayed due to complications, concurrent medical problems, pre-existing medical condition, subsequent trauma, etc? ☐ Yes ☐ No If Yes, please explain condition and how it has affected recovery.

7. Will claimant need rehabilitation services? ☐ Yes ☐ No If Yes, please specify.

8. Is claimant temporarily and totally disabled? ☑ Yes ☐ No If Yes, is disability due to compensable diagnosis or other causes? Please explain.

9. Please indicate the anticipated date claimant will be able to return to:
Modified Work ____ Trial Return to Work 6/05/01 Full-time Work ____

10. If the claimant has reached maximum medical improvement, is there, or do you anticipate, any permanent impairment as a result of the compensable injury? ☐ Yes ☐ No If Yes, please complete form WC-219a, Notice of Maximum Medical Improvement.

11. Physician's Name, Address & Telephone No.

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

Phone: 304-369-5170

FEIN 550664546

12. [signature] Physician's Signature

5-25-01 Date

MADISON MEDICAL, P.L.L.C.
705 MADISON AVENUE
MADISON, WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

FAX COVER SHEET

TO: Erica / Dr Surface

FROM: Freda / Dr Snyder

RE: Chris Lester

NUMBER OF PAGES INCLUDING COVER SHEET: 6

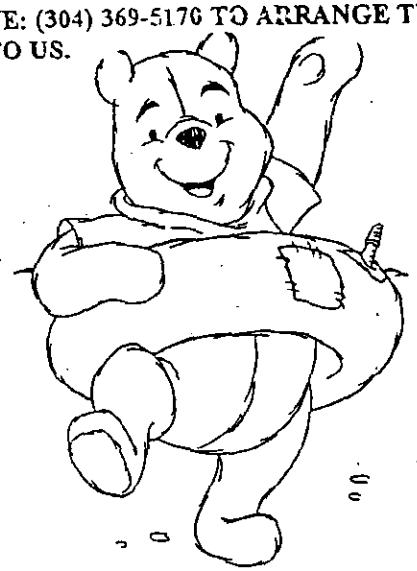
DATE: 5-21-01

ADDITIONAL COMMENTS: film report

CONFIDENTIALLY NOTICE: THE DOCUMENTS ACCOMPANYING THIS FACSMILE TRANSMISSION CONTAIN CONFIDENTIAL INFORMATION BELONGING TO THE SENDER WHICH IS LEGALLY PRIVILEGED. IF YOU ARE NOT THE INTENDED RECIPIENT YOU ARE HEREBY NOTIFIED THAT ANY DISCLOSURE, COPYING, DISTRIBUTION OR TAKING OF ANY ACTION IN RELIANCE ON THE CONTENTS OF THIS TELECOPIED INFORMATION IS STRICTLY PROHIBITED. IF YOU RECEIVED THIS FACSMILE IN ERROR PLEASE NOTIFY US BY TELEPHONE: (304) 369-5170 TO ARRANGE THE RETURN OF THE ORIGINAL DOCUMENTS TO US.

THANK YOU.

FAXED 5-21-01 fs



MADISON MEDICAL, PLLC
705 MADISON AVENUE
MADISON, WV 25130
(304) 369-5170 FAX (304) 369-1742

PATIENT NAME [redacted]/Chris Lester ACCT # 49564

DX: Chronic LBP & Rt shoulder pain & neck pain

AUTHORIZATION # Work's Comp #3000/0775

REFERRING DOCTOR 3

PHONE # 369-6657 CONTACT NAME 369-9296 wk/April

REQUEST FOR: oral,

SCHEDULED WITH Pain Clinic - Dr Saldanha 925-3535

DATE/TIME Scheduled for 9/01 1 month w injections & Clinic

RECORDS:

_____ SENT BY MAIL

conf auth 5211 FAXED 925-2924

_____ GIVEN TO PT TO HAND DELIVER

_____ PT WAS NOTIFIED OF DATE, TIME AND ANY SPECIAL INSTRUCTIONS.

MADISON MEDICAL, P.L.L.C.
705 MADISON AVENUE
MADISON, WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

FAX COVER SHEET

TO: Mary / Dr Saldanha

FROM: Ineda / Dr Snyder

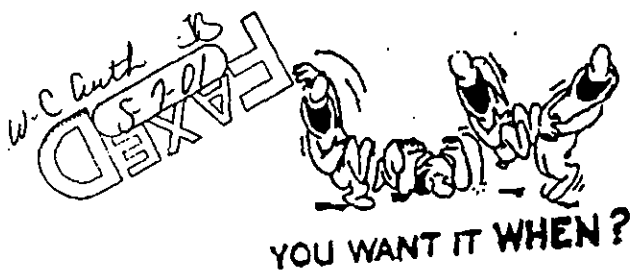
RE: Chris Lester 12/28/71

NUMBER OF PAGES INCLUDING COVER SHEET: 2

DATE: 5-7-01

ADDITIONAL COMMENTS:

THANK YOU.



Patient: Christopher Lester Date: 3-30-01

Social Security No.: [redacted]-3340

Birth Date: [redacted]-71

PHYSICAL CAPACITIES

PLEASE CHECK THE NUMBER OF HOURS THE PATIENT IS ABLE TO PERFORM THE FOLLOWING:

	Total hours per day
SIT	4
STAND	1
WALK	1

	Total hours at one time
SIT	1
STAND	10 min
WALK	10 min

Percentage of usual workday
Patient is able to:

	Not at All 0%	Occasionally 1%-33%	Frequently 34%-66%	Continuously 67%-100%
Bend/Stoop	✓	—	—	—
Squat	✓	—	—	—
Crawl	✓	—	—	—
Climb	✓	—	—	—
Reach above shoulder level	—	✓	—	—
Kneel	✓	—	—	—
Balance	—	—	✓	—

Percentage of usual workday
Patient is able to use head and neck:

	Not at All 0%	Occasionally 1%-33%	Frequently 34%-66%	Continuously 67%-100%
Extension movements	—	—	✓	—
Static position	—	—	✓	—
Rotation movements	—	—	✓	—
Flexing movements	—	—	✓	—

Patient Name: _____

Patient is able to carry:		Patient is able to Lift:	
Up to 10 pounds	Yes or No	Up to 10 pounds	Yes or No
11-24 pounds	Yes or No	11-24 pounds	Yes or No
25-34 pounds	Yes or No	25-34 pounds	Yes or No
35-50 pounds	Yes or No	35-50 pounds	Yes or No
51-74 pounds	Yes or No	51-74 pounds	Yes or No
75-100 pounds	Yes or No	75-100 pounds	Yes or No

Patient is able to use lower extremities and feet for repetitive movements as in operating foot controls.

Right Yes or No

Left Yes or No

Name of Physician: John M Sayer
(Printed)
Address: 705 Medical Arts Bldg
Madison WI 53715

Signature: _____ Date: 3/21/94

Attending Physician's Report

Return Completed Form To:
Workers' Compensation Division
P.O. Box 3151, Charleston, West Virginia 25332

FOR DIVISION USE ONLY
Claims Manager Rena Peay
Trucking/Agr & Food Proc
Claimant's County BOONE

C-219 Rev. 9-94

Claim No. 2000046841 SS No. [redacted]-3340 2. Current Telephone No. 304-369-6657
Emp. Fisk No. 98001651 DOI 03/10/2000

Claimant's Name and Address

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Employer's Name and Address

D & M TRUCKING CORPORATION
502 BOB VINES RD
GHENT, WV 25843

Please mark any needed changes in your address as printed above.

Have you performed any kind of work or have you received income for any work during the time you have been certified temporarily and totally disabled? ☐ Yes ☐ No

I hereby certify that the statements and answers set forth above are true and correct to the best of my knowledge and belief. I am aware that the law provides for severe penalties if I knowingly and with fraudulent intent withhold a material fact or make a false statement in order to obtain or increase a benefit that I am not entitled to.

Claimant's Signature _____ Date _____

If claimant has reached maximum degree of medical improvement, please complete form WC-219a, NOTICE OF MAXIMUM MEDICAL IMPROVEMENT.

1. Date of this examination 3/27/01 (Month Day Year) 2. Date of next appointment 4/24/01 (Month Day Year)

3. A. Is this the first examination and/or treatment by you for this injury? ☐ Yes ☒ No If Yes, please advise as to how the claimant came under your care. _____

B. Does claimant continue under your active care? ☒ Yes ☐ No If No, please explain. _____

C. Has the claimant been referred to another physician for any of the following? (Check appropriate box(es) and explain basis for your referral.)
☒ Consultation ☒ Evaluation ☒ Treatment Pain Management

4. Diagnosis (ICD9-CM) code and description
847.0 847.2
847.1 959.01

5. Please describe your *treatment plan* and *list medications* currently being prescribed, their dosages, and the refill limit.
continue meds
F/u with Pain Clinic
request consult c orthopedic surgeon

6. Has normal or expected recovery been delayed due to complications, concurrent medical problems, pre-existing medical condition, subsequent trauma, etc? ☐ Yes ☐ No If Yes, please explain condition and how it has affected recovery.

7. Will claimant need rehabilitation services? ☐ Yes ☐ No If Yes, please specify.

8. Is claimant temporarily and totally disabled? ☒ Yes ☐ No If Yes, is disability due to compensable diagnosis or other causes? Please explain.

9. Please indicate the anticipated date claimant will be able to return to:
Modified Work ____ Trial Return to Work 6/05/01 Full-time Work ____

10. If the claimant has reached maximum medical improvement, is there, or do you anticipate, any permanent impairment as a result of the compensable injury? ☐ Yes ☐ No If Yes, please complete form WC-219a, Notice of Maximum Medical Improvement.

11. Physician's Name, Address & Telephone No.

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

Phone: 304-369-5170

Faxed 4/2/01 3:30 PM

FEIN 550664546

12. _____ Physician's Signature

5-25-01 Date

500688.015.0290

MADISON MEDICAL, PLLC
705 Madison Avenue • Madison, WV 25130
Phone (304) 369-5170 • Fax (304) 369-1742

Robert B. Atkins, M.D.
Family Practice

John Mark Snyder, D.O.
General Practice

Ron D. Stollings, M.D.
Internal Medicine, Geriatrics

Barbara J. Koster, MSN-RNC
Nurse Practitioner

March 28. 2001

Worker's Compensation
P O Box 3151
Charleston, WV

RE: Christopher Lester
Claim No. [redacted]-3340
DOI 03/10/2000

To Whom It May Concern,

Mr. Lester would like to change orthopedic surgeons from Dr. Loimil to another physician. Dr. Loimil has only seen him on one occasion, there has been no therapy or surgery performed. I am requesting approval for consultation with Dr. Philip Surface, in South Charleston, WV. I would appreciate a positive reply.

Sincerely,

John M. Snyder, D. O.
JMS:bw

DAY SURGERY CENTER
HISTORY AND PHYSICAL

CHART # 3687

PATIENT: Christopher Lester
ADDRESS: P. O. Box 1113
Danville, WV 25053
PT'S DOB: 12/23/71

SS#: [redacted]3340
DOI: 03/10/00
CL#: 2000046841
PH#: 304-369-6657

EXAM DATE: February 28, 2001

REQUESTING CONSULTING PHYSICIAN: J. Mark Snyder, MD

EXAMINING PHYSICIAN: Francis M. Saldanha, MD

CHIEF COMPLAINT: Chronic low back pain, left shoulder pain, as well as some neck pain.

HISTORY OF PRESENT ILLNESS: Christopher Lester is a 29-year-old white male who was referred to me by Dr. Snyder. He suffered work-related injuries about a year ago. He suffered previous injuries in 1993, and was off for almost four and a half years. He was treated with trigger point injections, etc., by Dr. Nelson and eventually returned to work. He got hurt when he fell off a coal truck last March and has been under the care of Dr. Snyder. He has been off work since then. He is scheduled to follow up with Dr. Loimil regarding his left shoulder. He described chronic back pain, aggravated by increased walking, standing, twisting and bending, etc. He also noted that any range of motion involving the left shoulder girdle produced a lot of pain. He also has increasing pain in the neck.

REVIEW OF SYSTEMS: A review of systems indicates that he has problems with asthma. He has no hypertension, diabetes, bladder or bowel dysfunction.

NEURORADIOLOGIC WORKUP: His workup has been fairly extensive and it appears that his cervical and lumbar MRIs were negative for disc herniations, etc.

PFMSH: He used to work as a coal truck driver. He has had no surgical procedures in the past. There is no litigation pending and he does not smoke or consume alcoholic beverages.

CURRENT MEDICATION: His medications include OxyContin, Flexeril, Paxil and Ativan, prescribed by Dr. Snyder.

PHYSICAL EXAMINATION:

Vital signs: Blood pressure was 151/119, heart rate 89 and respiration 16.

Appearance and Demeanor: Friendly and cooperative.

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Gait: Slow and painful.

Ability to perform calf raises and squat: He cannot perform calf raises or squat.

Orientation to time, place and person: Normal.

Tests of coordination (finger/nose): Normal.

Cranial Nerves:
III, IV and VI: Normal eye movements.
V: Normal sensation over face
VII: Facial grimace, symmetrical.
VIII: No hearing impairment.
XI: Shoulder shrug equal.
XII: Tongue in the mid-line.

Stance: Painful.

Skin examined for scars, psoriasis, eczema, tattoos, etc.: Negative findings.

Cervical adenopathy: None.

Peripheral vascular system examined for edema, swelling and varicose veins: Negative findings.

Cervical/Thoracic Spine Exam:
Inspected for stiffness, torticollis, deviation, scoliosis, etc: Negative findings.

Palpated for significant tenderness of the paraspinous muscles, facet joints, spinous processes, etc.: Significant tenderness of the right paraspinous musculature.

Range of Motion: Within normal limits.

Lumbosacral Spine exam: Inspected for guarding, spasm, scoliosis, lordotic curve reduction or exaggeration, etc.: Negative findings.

Palpated for significant tenderness of the paraspinous muscles, spinous processes and facet joints: Significant tenderness of the lumbar facet joints on both sides.

Range of Motion: Significantly diminished in all directions.

Seated straight leg raising test: Negative at 90° on both sides, representing a positive Waddell's sign.

Extremities checked for muscle tone, wasting, atrophy, tremors, etc.: Negative.

Motor function checked for muscle strength in all extremities: 5/5 muscle strength in both lower extremities and the right upper extremity. There is discomfort in the left upper extremity during muscle strength examination.

Sensory function checked for perception to touch and pinwheel stimulation: Normal responses.

Reflexes including bilateral biceps, triceps, patella and ankle: Within normal limits.

DIAGNOSIS/TREATMENT PLAN AND RECOMMENDATIONS: Lumbar facet arthropathy and cervical strain, left shoulder arthrosis. I recommend two sessions of facet joint injections in the back and trigger point injections in the neck. I'll proceed as soon as authorization has been obtained. I will defer any treatment regarding his left shoulder to Dr. Loimil. I recommend that Dr. Snyder continue his medications after the low back injections have been completed. I feel he may be deemed as having reached MMI regarding the low back, but that decision will have to be made by Dr. Snyder and Dr. Mir. FMS/las

Francis M. Saldanha, MD

D: 02-28-01
T: 03-05-01
cc: Christopher Lester
J. Mark Snyder, MD
Saghir, Mir, MD
WV Workers' Compensation

extt/01-01-96/*6 ** VENDOR COPY ** 1024458

Bob Wise
Governor

Robert J. Smith
Commissioner

West Virginia Bureau of Employment Programs
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March 20, 2001

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Re: Claim 2000046841
S.S.N. [redacted]-3340
D.O.I. 03/10/2000

PLEASE READ CAREFULLY - NOTICE OF BENEFITS

I have received medical evidence which indicates you continue to be disabled from working from 07/01/2000 through 03/11/2001.

If it is later determined you are not entitled to benefits or expenses, the Division may recover these overpayments.

If medical evidence showing continued disability is not received, your claim may close for temporary total disability benefits on 05/03/2001.

If you have any questions or concerns, you may reach me at 304-926-5097.

Workers' Compensation Division
By: Nena Peay
Claims Representative 3/Senior

CC: D & M TRUCKING CORPORATION INC
KOZAK JOHN H
VASS VOCATIONAL SERVICES

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P. 1

* * * Transmission Result Report (MemoryTX) (Mar.14. 2001 3:32PM) * * *

Ie lo. Mode	Destination	Pg(s)	Result	Page Not Sent
'19 Memory TX	13049266092	P. 2	OK	

Reason for error
E.1) Hang up or line fail
E.2) Busy
E.3) No answer
E.4) No facsimile connection

MADISON MEDICAL, P.L.L.C
705 MADISON AVE.
MADISON, WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

FAX COVER SHEET

TO: Workers Comp Attn Nena Peay

FROM: Debbie / Dr. J.M. Snyder II

RE: Christopher Lester - 2000046841

NUMBER OF PAGES INCLUDING COVER SHEET: 2

DATE: 3/14/01

ADDITIONAL COMMENTS: Rx auth

CONFIDENTIALITY NOTICE: THE DOCUMENTS ACCOMPANYING THIS FACSMILE TRANSMISSION CONTAIN CONFIDENTIAL INFORMATION BELONGING TO THE SENDER WHICH IS LEGALLY PRIVILEGED. IF YOU ARE NOT THE INTENDED RECIPIENT YOU ARE HEREBY NOTIFIED THAT ANY DISCLOSURE, COPYING, DISTRIBUTION OR TAKING OF ANY ACTION IN RELIANCE ON THE CONTENTS OF THIS TELECOPIED INFORMATION IS STRICTLY PROHIBITED. IF YOU RECEIVED THIS FACSMILE IN ERROR PLEASE NOTIFY US BY TELEPHONE 304-369-5170 TO ARRANGE THE RETURN OF THE ORIGINAL DOCUMENTS TO US. THANKYOU.

MADISON MEDICAL, P.L.L.C
705 MADISON AVE.
MADISON, WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

FAX COVER SHEET

TO: Workers Comp Attn Nena Peay

FROM: Debbie / Dr. J.M. Snyder

RE: Christopher Lester - 2000046841

NUMBER OF PAGES INCLUDING COVER SHEET: 2

DATE: 3/14/01

ADDITIONAL COMMENTS: Rx auth

FAXED 3/14/01

MADISON MEDICAL, PLLC
705 MADISON AVENUE
MADISON, WV 25130
(304) 369-5170

WV Worker's Compensation
P. O. Box 431
Charleston, WV 25322-0431

To Whom It May Concern:

Please authorize the purchase of the following medications for this patient for the treatment of his/her compensable injury.

Sincerely, Debbie

Patient: Christopher Lester 2000046841

SSN: [redacted]-3340

DOI: 3-10-00

RX'S Oxy Contin 40mg 1 TID
Flexeril 10mg 1 TID
Paxil 20mg 1 BID
ATIVAN 1mg 1 BID

For the treatment of: 847.0, 847.1, 847.2, 959.01

FAXED 3/14/01 DH

500688.015.0298

MADISON MEDICAL, P.L.L.C.
705 MADISON AVENUE
MADISON, WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

FAX COVER SHEET

TO: Gloria / Dr Rias

FROM: Freda / Dr Snyder

RE: Chris Lester

NUMBER OF PAGES INCLUDING COVER SHEET: 2

DATE: 3-14-01

ADDITIONAL COMMENTS:

THANK YOU.

FAXED 3-14-01 W-Court/304

auth/09-24-98/*8 ** VENDOR COPY ** 1024458

Bob Wise
Governor

Robert J. Smith
Commissioner

West Virginia Bureau of Employment Programs
• Job Service/Job Training Programs • Labor Market Information
• Unemployment Compensation • Workers' Compensation
an equal opportunity/affirmative action employer

March 2, 2001

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Re: Claim 2000046841
S.S.N. [redacted]-3340
D.O.I. 03/10/2000

PLEASE READ CAREFULLY - AUTHORIZATION DECISION

The request from WCD-CLAIM MANAGER dated 02/28/2001, is Approved.

per the recommendations of the examiner, authorization for psychiatric consultation with physician of claimant's choice

dos 3-5-01 SD

Authorized Dates are 03/01/2001 through 06/01/2001.

Your authorization number is 300002505.

For procedures, such as surgery, that are authorized and require multiple providers, the attending physician should share the authorization number with those providers to assure payment of their bills.

If it is later determined you are not entitled to authorized services, payment will be recovered.

Any party to this claim may protest this decision within 30 days from the date you receive this letter. You must send a written protest, along with a copy of this order, to the Office of Judges, P.O. Box 2233, Charleston, WV 25328-2233 and to the Supervisor, Claims Defense Litigation, P.O. Box 4317, Charleston, WV 25364-4317. Copies must also be sent to all other parties to the claim.

After the protest is filed, all parties may agree to seek mediation services. If so, you may contact the Mediation Unit at P.O. Box 2964, Charleston, WV 25330-2964.

If you have any questions or concerns, you may reach me at 304-926-5097.
Workers' Compensation Division
BY: Nena Peay
Claims Representative 3/Senior

CC: D & M TRUCKING CORPORATION INC

KOZAK JOHN H
VASS VOCATIONAL SERVICES

RECEIVED MAR 0 5 2001